CHAPTER IV

COVERED SERVICES, LIMITATIONS, AND PAYMENT

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GENERAL INFORMATION

The provision of medically necessary artificial arms, legs, their necessary supportive devices, and breast prostheses to Medicaid-eligible recipients in the Commonwealth of Virginia is a service requiring prior approval.

COVERAGE AND LIMITATIONS

A. Prosthetic services shall mean the replacement of missing arms, legs, eyes, and breasts and the provision of an internal (implant) body part. Nothing in this regulation shall be construed to refer to orthotic services or devices or organ transplantation services.

B. Artificial arms and legs, and their necessary supportive attachments, implants, and breasts are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional license as defined by state law. This service, when provided by an authorized vendor, must be medically necessary, and pre-authorized for the minimum applicable component necessary for the activities of daily living (ADLs).

C. Eye prostheses are provided when eyeballs are missing regardless of the age of the recipient or the cause of the loss of the eyeball. Eye prostheses are provided regardless of the function of the eye. Pre-authorization is not required, but post-payment review is conducted.

To obtain the required pre-authorization for coverage, the prosthetist will ask the prescribing practitioner to complete a DMAS Certificate of Need form (DMAS-4001). The prosthetist will then submit the Certificate of Need, a copy of the physician's prescription, and a completed Prosthetic Device Pre-authorization Request form (DMAS-4000) to:

Director of Medical Support
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

NON-COVERED SERVICES

The following devices are not covered for adults:

- Orthotic Devices - Spinal
- Orthotic Devices - Cervical
- Orthotic Devices - Thoracic
- Orthotic Devices - Sacral
- Orthopedic Footwear
- Orthopedic Footwear Modifications
- Shoe Modifications
- Trusses
- Penile Prostheses (exception of implants)

PAYMENT FOR SERVICES

General Information

The payment criteria established for prosthetic devices are designed to enlist the participation of a sufficient number of suppliers so that Medicaid-eligible persons receive prostheses at least to the extent that they are available to the general population.

Participation as a prosthetic provider is limited to those who accept the amount paid by the Virginia Medicaid Program as payment in full.

Payment for services will not exceed the amount indicated to be paid in accordance with the policy and methods described in the State Plan for Medical Assistance, and payment will not be made in excess of the upper limits described in 42 CFR § 447.304(a).

Federal requirements prohibit Medicaid from paying prosthetic device providers **more** than Medicare would allow for the same service.

Payment Methodology

Payment for prostheses is the lowest of Medicaid's fee schedule, the actual charge, or the Medicare allowance.

For Medicare crossover claims, the payment will be the deductible and co-insurance amounts computed by Medicare based on the Medicare-allowed charge, as reported on the Explanation of Medicare Benefits (EOMB) received from the Medicare carrier.

Cost Sharing

There are no Medicaid deductible or co-insurance amounts imposed for any prosthetic device provided to Medicaid recipients. As previously mentioned, Medicaid will pay the deductible and co-insurance amounts imposed on Medicaid recipients who are also Medicare beneficiaries and whose claims the Medicare carrier processes initially.

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to certain low-income Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMBs).

QMB Coverage Only

Qualified Medicare Beneficiaries (QMBs) are only eligible for Medicaid coverage of Medicare premiums and of deductible and co-insurance up to the Medicaid payment limit less the recipient's co-payment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB-MEDICAID PAYMENT LIMITED TO MEDICARE COINSURANCE AND DEDUCTIBLE." The Medicare co-insurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage

Recipients in this group will be eligible for Medicaid coverage of Medicare premiums and of deductible and co-insurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB EXTENDED." These recipients are responsible for the Medicaid co-payments.

All Others

Recipients without either of these messages on their Medicaid cards will be eligible for those covered services listed in Chapter I of this manual.

RECIPIENT APPEALS OF DENIAL OF SERVICES

Reductions in service, suspensions, terminations, and denials may be appealed to the Department of Medical Assistance Services (DMAS). Furthermore, an agency's failure to process a request for services within required time frames is an appealable issue. The recipient or his/her authorized representative must appeal the decision in writing within 30 days of the date of the decision notification. When filing an appeal request, it would be helpful to include a copy of the notice or letter about the action being appealed. Appeals should be directed to:

Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

EXHIBITS

VIRGINIA MEDICAL ASSISTANCE PROGRAM
PROSTHETIC DEVICE PREAUTHORIZATION REQUEST FORM

1. DATE _____
2. PATIENT'S NAME _____
3. PATIENT'S MEDICAID NUMBER _____
4. PATIENT'S MEDICARE NUMBER _____
5. NAME OF PRESCRIBING PHYSICIAN _____
6. DOCTOR _____ PRESCRIPTION INCLUDES THESE ITEMS:

	HCPCS CODE(S)	DESCRIPTION
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		

7. DIAGNOSIS _____
8. FUNCTIONAL LIMITATIONS _____
9. DEVICE ACCEPTANCE _____
10. PSYCHOLOGICAL/THERAPEUTIC VALUE _____
11. EMPLOYMENT POSSIBILITY _____
12. PROSTHETIC DEVICE HISTORY _____

PROVIDERS STATEMENT

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this request will be from federal and state funds, and that any false statements or documents or concealment of a material fact, may be prosecuted under applicable federal and state laws.

13. SUBMITTED BY _____
14. PROVIDER NUMBER _____
    PROVIDER ADDRESS _____
    _____
    _____
15. SIGNATURE OF PROVIDER/AGENT _____
16. DATE _____ 17. TELEPHONE (_____) _____

FOR OFFICE USE ONLY

APPROVED _____
DENIED _____
PENDING _____
COMMENTS:

REVIEWER SIGNATURE _____ DATE _____

Preauthorization

A Prosthetic Device Preauthorization Request must be completed and submitted to the Department of Medical Assistance Services for reimbursement approval for prosthetic devices which have been prescribed by a practitioner within the scope of his licensure. A copy of the prescription must be attached to the request.

Item 1. Enter the date the form is prepared

Item 2. Enter the name of the patient

Item 3. Enter the patient's 12-digit Medicaid number

Item 4. Enter the patient's Medicare number

Item 5. Enter name of prescribing physician

Item 6. Use as many lines as necessary to describe the prosthetic device and required supportive items

Item 7. Enter the diagnosis of the patient's condition if available.

Item 8. Describe the patient's functional limitations.

Item 9. Enter a comment regarding acceptance of the device by the patient.

Item 10. Enter psychological and/or therapeutic value expected for the patient.

Item 11. Enter any employment possibility.

Item 13. Enter name of prosthetic device participating provider submitting the request.

Item 14. Enter the Medicaid provider number assigned to the provider.

Item 15. Enter the providers or agents signature

Item 16. Enter date signed.

Item 17. Enter telephone number for inquiries.

Item 18. To be completed by Medicaid office.

COMPLETED PROSTHETIC DEVICE PREAUTHORIZATION REQUEST FORM ARE ADDRESSED TO:

Department of Medical Assistance Services
Director, Medical Support
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

PHYSICIAN CERTIFICATION OF NEED

Dear Doctor:

To expedite the processing of request for funding of prosthetic devices for your patient, the Department of Medical Assistance Services seeks your assistance in contributing medical information so that an appropriate decision can be made promptly. Please complete the following where applicable and forward to the prosthetist for their submission with the preauthorization request form or send to Medical Support Section, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

1. _____ Patient's Name

2. _____ Medicaid Recipient I.D. Number

3. _____ Date of Amputation

4. _____ Date of Birth

5. _____ Weight

6. _____ Height

7. _____ Diagnosis

8. _____ Reason for Amputation

9. Are other amputations anticipated within the next twelve months?

10. If this patient has undergone a lower extremity amputation, please include the date the patient last ambulated:

11. Please list any current significant medical conditions and their present treatments, e.g. arthritis, vascular disease, neuropathy, diabetes:

12. Is the patient cognitive and physical status sufficient to enable learning the use of a prosthesis?

13. If the patient has had a prosthetic limb, why does it need to be replaced or repaired?

14. Additional medical justification for special prosthetic components, e.g. lightweight equipment, special terminal devices, modified sockets, modified feet, etc.:

PHYSICAL EXAMINATION

15. Please indicate strength testing of all extremities, including range of motion across all joints. This should include the contralateral limb:

16. Are there any signs on examination consistent with vascular disease in the contralateral limb? Give it's present condition and viability.

17. Are there any conditions that would preclude or delay the use of prosthesis, i.e., edema, open wound, contractures or poor skin viability?

18. _____ Physician's Name

19. _____ Physician's Signature _____ Date

20. _____ Street Address

21. _____ Physician's Phone Number

_____ City, State, Zip Code

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